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ABSTRACT

The California Office of Family Planning (OFP), a branch of the Family Health Division, Department of Health Services, was established in 1973 to provide assistance and services relating to the planning of families. In July 1989, state appropriations for OFP were cut by two-thirds, leaving $12 million to support the provision of family planning and other health services. Funding was restored 7 months later. Prior to the restoration of funds, the California Assembly Committee on Health mailed a written questionnaire to OFP-funded agencies to document effects of the cutbacks. This survey revealed 28 clinic site closures and 4 clinics that discontinued providing family planning services. An additional 43 clinics stopped serving OFP-subsidized clients. Thus a total of 75 clinics were affected, leading to reduced accessibility to subsidized family planning services in 20 counties. The temporary reduction in funding has had long-term consequences. Most dramatic has been the inability to recruit the nurse practitioners who form the backbone of clinic services. Many of these professionals sought employment élsewhere because of the instability of program funding as well as the relatively low salaries. Continued state funding of the network of family planning clinics throughout California is imperative if women at risk of unintended pregnancy are to be served. As this study documents, even within the relatively short period during which OFP funds were curtailed, the subsidized clinics were severely affected. (LLL)

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THE IMPACT ON CLINICS OF THE CALIFORNIA OFFICE OF FAMILY PLANNING BUDGET CUTS

Claire Brindis
Patricia Reyes and Madeline Stanionis
and
Brian Uslan and M. Anne Powell

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The Impact on Clinics of the California Office of Family Planning Budget Cuts

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EXECUTIVE SUMMARY

The California Office of Family Planning (OFP), a branch of the Family Health Division, Department of Health Services, was established in 1973 "to make available to citizens of the state of childbearing age comprehensive medical knowledge, assistance and services relating to the planning of families." In July 1989, state appropriations for OFP were cut by two-thirds, leaving $12 million to support the provision of family planning and other health services. Funding was restored seven months later.

These cuts were particularly significant for low-income women, many of whom use family planning clinics as their primary health care provider. These women have come to depend on these providers not only for their birth control method but also, if necessary, for sexually transmitted disease testing, dysplasia diagnosis and treatment, screening for breast cancer and high blood pressure, and for referrals such as for prenatal care.

Prior to the restoration of funds, the California Assembly Committee on Health mailed a written questionnaire to OFP-funded agencies to document the effects of the cutbacks. This survey revealed 28 clinic site closures and four clinics that discontinued providing family planning services. An additional 43 clinics stopped serving OFP-subsidized clients. Thus a total of 75 clinics were affected, leading to reduced accessibility to subsidized family planning services in 20 counties.

In addition, clinics across the state were affected in the following ways:

- Thirty-two percent (74) of 229 responding clinics reduced the number of clinic hours available to family planning clients.

- Eighty-seven percent (201) of responding clinics indicated they were able to provide requested appointments within two weeks or less in FY 1988-89; after budget reductions, only 63 percent (145) of the clinics reported that they were able to provide appointments within two weeks of a request.

- Fifty-one percent (112) of 218 responding clinics decreased their clinical and/or support staff.

- Forty percent (79) of 199 responding clinics turned clients away due to insufficient funding. Only 4 percent (9) of 233 responding clinics had to turn clients away the previous year.

- The number of visits billed to OFP decreased by 28 percent from FY 1988-89 to FY 1989-90.

- During the period of the cutbacks there was reduced access to services that were no longer reimbursed by OFP, including sexually transmitted disease testing, dysplasia diagnosis and treatment, and pregnancy-testing-only services.

- OFP Information and Education projects served 12 percent fewer people in FY 1989-90 than in the previous year through community-based presentations to adolescents, parents, teachers, health providers, human service agency staff and persons with special needs, such as incarcerated youth, refugees, and immigrants.

- Thirteen of the 55 originally funded Information and Education projects did not restart when funds were restored.

The temporary reduction in funding for many clinics had long-term consequences. Most dramatic has been the inability to recruit the nurse practitioners who form the backbone of clinic services. Many of these professionals sought employment elsewhere because of the instability of program funding as well as the relatively low salaries at OFP-funded clinics. In addition, family planning clinics continue to experience difficulty with the low level of reimbursement rates that are provided under their current contracts.

Continued state funding of the network of family planning clinics throughout California is imperative if women at risk of unintended pregnancy are to be served. As this study documents, even within the relatively short period during which OFP funds were curtailed, the subsidized clinics were severely affected by the cutback. The temporary budget reduction clearly restricted access to family planning and basic health services for a large number of women at risk for unintended pregnancy. Stable funding and a commitment to the program by state leaders and policymakers are crucial to maintaining a system of family planning care that responds to California's growing needs.

INTRODUCTION AND BACKGROUND

The California Office of Family Planning

The California Office of Family Planning (OFP), established in 1973, funds family planning clinics in a variety of settings, including health departments, community and free clinics, licensed independent clinics, and hospitals to provide family planning and related services to low-income women and men. OFP-funded agencies* make available a full array of contraceptive methods and screen for sexually transmitted diseases (including HIV testing and counseling at selected clinics), breast and cervical cancer, high blood pressure, and anemia. Family planning clinics are the primary health care provider for many low-income women and provide referrals for a variety of community health and social service programs. Contraceptive counseling and education are provided so that the client can make an informed choice of method, and a complete health history is taken and updated annually. Male clients, constituting fewer than 1 percent of total clients served, can receive family planning counseling and education and may receive condoms and contraceptive foam at these clinics. Treatment services for sexually transmitted diseases are available to male sexual partners of female OFP contraceptive clients. Male and female sterilization and infertility services are made available at some clinics.

In addition to funding family planning clinics, the Office of Family Planning provides a variety of educational programs through school and community-based presentations for adolescents, parents, teachers, health providers, human services agency staff, and persons with special needs, such as incarcerated youth, refugees, and immigrants. These programs address such topics as family life education, parent/child communication, abstinence, and the male role in family planning. The OFP also sponsors statewide programs that provide professional training and continuing education for nurses, physicians, and other clinic workers.

State OFP funds in the amount of $29.7 million were allocated for family planning clinical services in Fiscal Year 1988-89 and were used to support a network of 473 family planning clinics located throughout the state. In FY 1988-89 nearly 50 percent of all OFP clients received services in four of California's 58 counties: Los Angeles (127,702), San Diego (52,658), Orange (32,488), and San Bernardino (20,243) (OFP Annual Report, 1988/89). It is important to note that OFP funding to this network of clinics is supplemented by non-OFP-funded clients whose visits are reimbursed through third-party coverage, such as Medi-Cal and private insurance; by clients who pay directly out of pocket for services; private fundraising efforts (in the case of some clinics); and by other payment sources such as funds from the federal Title X Program of the Public Health

* In this paper *agency* refers to the organization that contracts with the OFP and *clinic* refers to the site where family planning services are provided. Each agency may have multiple clinics.

Service Act. In 1989, approximately $10.8 million in Title X funds was available in California for direct services.

All clinics determine first if clients are eligible for Medi-Cal or other health care coverage, and utilize this source of funding whenever feasible. Clients whose services are directly funded by OFP (OFP-subsidized clients) comprise the group who are in greatest need of subsidized services because their income level is 200 percent or less of the federal poverty level. For example, effective July 1, 1990 a family of four earning $2,117 a month or less would meet the OFP income eligibility guidelines (OFP, June 21, 1990). Copayment fees paid by OFP clients are determined through a sliding scale that reflects family income and the number of people in the household. A woman in a 4-person family who is eligible for services would pay up to $26 (depending upon income) for an initial or annual visit. Effective February 1, 1990, persons at or below 100 percent of the federal poverty level are not subject to copayment fees. For purposes of eligibility, unmarried teens without children are considered on the basis of their own income and may be subject to copayment fees.

Family planning services benefit not only individual clients but the state as well. For every dollar spent by the state for OFP-clinic female contraceptive services in 1987-88, the expected savings to the state in other medical and social service costs was at least $12.20 (Brindis & Korenbrot, 1989). In addition, there are expected savings from early detection and treatment of breast and cervical cancer and sexually transmitted diseases.

Budgetary Cutbacks to the Office of Family Planning

In January 1989, Governor Deukmejian submitted a budget to the Legislature proposing to cut the OFP by two-thirds. Although the Legislature proposed reinstating the full $36.2 million in OFP funding during the budget process, the budget signed by the Governor on July 6, 1989 reduced the allocation to $12.1 million. Funding was restored in February 1990.

Although funding was not completely eliminated for any OFP-funded agencies, funding reductions ranging from two-thirds to one-quarter of their original allocation were experienced by all agencies providing clinical services, information and education projects, and statewide training programs. To determine funding reductions, the OFP took into consideration other sources of public funds available to each agency that could be used for family planning services.*

---

* Contractors for clinical services were grouped into four categories: 1) Contractors with $60,000 or less in OFP funds, and with no other source of family planning or primary care funding, received approximately three-fourths of their original allocation; 2) contractors with greater than $60,000 in OFP funds, and with no other source of family planning or primary care funding, received approximately one-half their original allocation; 3) contractors receiving federal Title X family planning funds received approximately one-half of their *combined* OFP and Title X funds; and 4) contractors receiving primary care funding received approximately one-third of their original allocation (OFP letter to contractors, August 8, 1989).

Clinic contractors who agreed to continue providing contraceptive services at a reduced level of funding were allowed to continue or cease providing sterilization and infertility services. Although male and female sterilization and infertility services continued after the budget cut, funding for these services was cut by two-thirds. With the restoration, funds were reinstated to 80 percent of the original contract amount. Services that were considered optional prior to the cuts were not reimbursed by OFP during the cutback. The services that were not reimbursed by OFP were dysplasia diagnosis and treatment services, male sexually transmitted disease (STD) services, and pregnancy testing only (i.e., women who come to the clinic solely for a pregnancy test, but who are not otherwise contraceptive clients). Faced with a lack of state OFP funding, clinics with other sources of funding were sometimes able to continue to provide these services. However, many clinics had to cease providing these optional services in order to provide basic contraceptive services.

Several workshops to help agencies survive the financial crisis caused by the drop in funding were sponsored by OFP and Title X. The Center for Health Training (an OFP contractor that provides statewide training programs) conducted five workshops on "Surviving Cutbacks" and "Medi-Cal Eligibility and Billing" during the period that clinic funding was reduced. In "Surviving Cutbacks," participants shared survival strategies that were found to be effective, a presentation was made concerning Title X service delivery requirements, and participants were trained in cost-based fee development and effective fee collection. The Medi-Cal seminar covered eligibility and billing as well as reimbursement.

Workshop participants also discussed the barriers faced by clients trying to enroll in Medi-Cal. These barriers included lengthy waits to talk to an eligibility worker, a long application form, limited office hours, client distrust of the welfare system, reduced confidentiality, and the need for clients to remember to bring their Medi-Cal card for visits. For teenagers, these barriers are particularly formidable. Although it takes less time to complete the application form when applying for "minor consent services" (because fewer items related to assets are applicable) and the enrollment process is faster, clients and eligibility workers need to be aware that this option for adolescents exists. Workshop participants also observed that they were losing large numbers of their adolescent clients, but due to confidentiality requirements and staffing resources they were unable to trace whether these clients stopped seeking care altogether or whether they had found an alternative site for family planning care.

In the months immediately following the budget reduction, family planning clinics attempted to remain open by using a variety of strategies in anticipation of restored funding. Some counties were successful in strengthening a working relationship with their local Medi-Cal eligibility offices so that clients could be certified as Medi-Cal eligible at the clinic itself. A number of clinics sought funding from private foundations and utilized those funds to support special efforts to reach at-risk populations such as adolescents. Foundation funds were used in some clinics to defray the costs of providing family planning services, although it was clearly understood that these grants

were "one-time-only" funds, and would not be available on an ongoing basis. A few clinics also sought assistance from local county boards of supervisors for temporary "bridging grants" to support programs during what was hoped would be a short-term crisis. Family planning programs in San Francisco and San Bernardino counties obtained such funding with the understanding that it could be used to help support programs for only a brief period of time. Given the worsening fiscal crisis faced by counties throughout the state and their increasing difficulty in paying for health care and many other services, emergency appropriations for family planning services had to be limited in both amount and duration. Some clinics instituted other kinds of fundraising efforts, in addition to asking clients for out-of-pocket payment for services.

Restoration of Funds

A grass-roots and legislative response began with the Governor's originally proposed budget cuts and continued until the funds were reinstated to the OFP. Family planning supporters throughout California were part of an organized, multifaceted effort that included a major media campaign, lobbying of members of the California Legislature, a letter-writing campaign and a rally in Sacramento.

Much of this activity occurred concurrently with a court suit seeking to mandate restoration of the deleted funds. Dr. Kenneth Kizer, Director of the State Department of Health Services, and State Controller Gray Davis were sued by California Rural Legal Assistance and the National Health Law Program on behalf of a small rural clinic in San Luis Obispo, a clinic physician, and two of the clinic's patients. The suit argued that state law required the provision of state funding for family planning services for all eligible persons, and that by reducing provider funding the state violated contracts that were in place prior to the Governor's line-item veto of the family planning money (PPAC Memo, Winter 1990). After successfully making its way through the lower courts, the suit was appealed by the State to the California Supreme Court, which ordered an injunction barring the restoration of funds. The suit was to be heard at approximately the same time that legislators were voting to restore family planning funds.

Meanwhile, the Legislature continued to address the issue of OFP funding. The result was a bill (AB99) whose principal authors were Assemblyman Bruce Bronzan (D-Fresno) and Senator Rebecca Morgan (R-Menlo Park) and which had strong bipartisan support. Governor Deukmejian allowed AB99 to become law February 1, 1990 without his signature, thus restoring $20 million to the state's family planning programs ($4 million less than the amount originally budgeted for 1989-90). However, this action did not come until after 75 clinics in 20 counties were forced either to close, to discontinue providing family planning services, or to stop serving OFP clients as a result of the crisis, and it is probable that many more clinics would have closed their doors had they faced continued restricted funding levels.

OFP Contractor Survey

On November 15, 1989, prior to the restoration of funds, the California Assembly Committee on Health mailed a written questionnaire to OFP-funded agencies to document the effects of the cutbacks. The survey addressed issues relating to how clinics were coping financially with the cutbacks, how the funding cuts had affected the availability of services, and expectations for the future should funding not be restored. This report presents findings from that survey. A thorough and comprehensive study examining the effects of the budget cuts at both the provider and client levels would present a more complete picture of the effects of the funding cuts than this report is capable of. A study of this type would include: 1) personal interviews with clients and family planning providers, 2) an analysis of Medi-Cal data showing changes in family planning billing, and 3) changes in the numbers of subsidized births and abortions. However, such impediments as the difficulty of conducting retroactive interviews with clients (whose names and visits are confidential), problems with documentation at the local clinic level, and the relatively brief period of time during which the funding cuts were in place rendered such a study infeasible. This report therefore presents an analysis of the surveys that were completed by clinics from throughout the state as they found themselves coping with the budgetary cuts in the midst of the crisis.

METHODOLOGY

The Assembly Committee on Health designed and pilot-tested a written, structured questionnaire to document both the actual effects of the funding cuts and the anticipated effects if OFP funding were not restored. In mid-November, 1989 the survey was sent to 130 agencies (representing 401 clinics) listed on a 1988/1989 OFP mailing list.* Agencies were asked to complete one survey for each clinic. In January, 1990 the Assembly Committee on Health contacted the Local County Health Officers Association, Planned Parenthood Affiliates of California, and the California Reproductive Health Association. These three organizations, representing many of the clinics being surveyed, encouraged their clinic members to complete and return the questionnaire. All completed questionnaires were returned by the end of February 1990. Eighty-five agencies (representing 248 clinics) responded to the survey - a response rate of 65 percent of the OFP-funded agencies surveyed and 62 percent of the total number of clinics.

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* As the number of existing sites fluctuates throughout the year, this mailing list may not have included all funded sites.

Coding was completed by Assembly Health Committee staff, and an analyst from the Joint Rules Committee managed the database, conducting analyses using the SAS statistical package. The Center for Reproductive Health Policy Research, Institute for Health Policy Studies, University of California, San Francisco (Center), was asked to assist the Assembly Health Committee by completing and verifying the questionnaire coding, planning and conducting the data analysis of survey responses, and preparing a report of findings. The following study analysis was funded by a grant from the California Policy Seminar.

Limitations. One of the study's limitations is the relatively low response rate of 62 percent, which restricted the information available on clinics that did not complete a written survey. Although Center staff called agencies that did not respond to the survey to determine how clinics were affected by the funding cuts (i.e., whether they remained open, closed, or had discontinued providing family planning services), it is not known how nonrespondents may have differed from respondents on the majority of survey items.

The findings from this report rely solely on clinic records, and their directors' recollections and projections. The Center did not attempt to independently verify the information provided by the completed surveys and telephone interviews. The resulting data are therefore subject to the potential questions concerning reliability and validity that unavoidably characterize self-reported information.

Another difficulty that presented itself derives from the number of different individuals responsible for the survey's development and implementation at various stages. As a result of the Legislature's immediate need for data, the questionnaire was designed rapidly, and the ambiguous wording of some of the questions and response categories resulted in differences in interpretation among survey respondents. The consequent inconsistencies among surveyed clinics in how the data were reported presented difficulties when attempting to analyze responses. Only findings that appear to be reliable and valid have been included here.

FINDINGS

This report presents findings in four major areas: 1) characteristics and referral patterns of clinics that had closed or discontinued providing family planning services during the seven-month period of funding reduction, 2) service changes for those still providing family planning services, 3) funding patterns and strategies adopted in response to the cutbacks, and 4) changes in client use patterns.

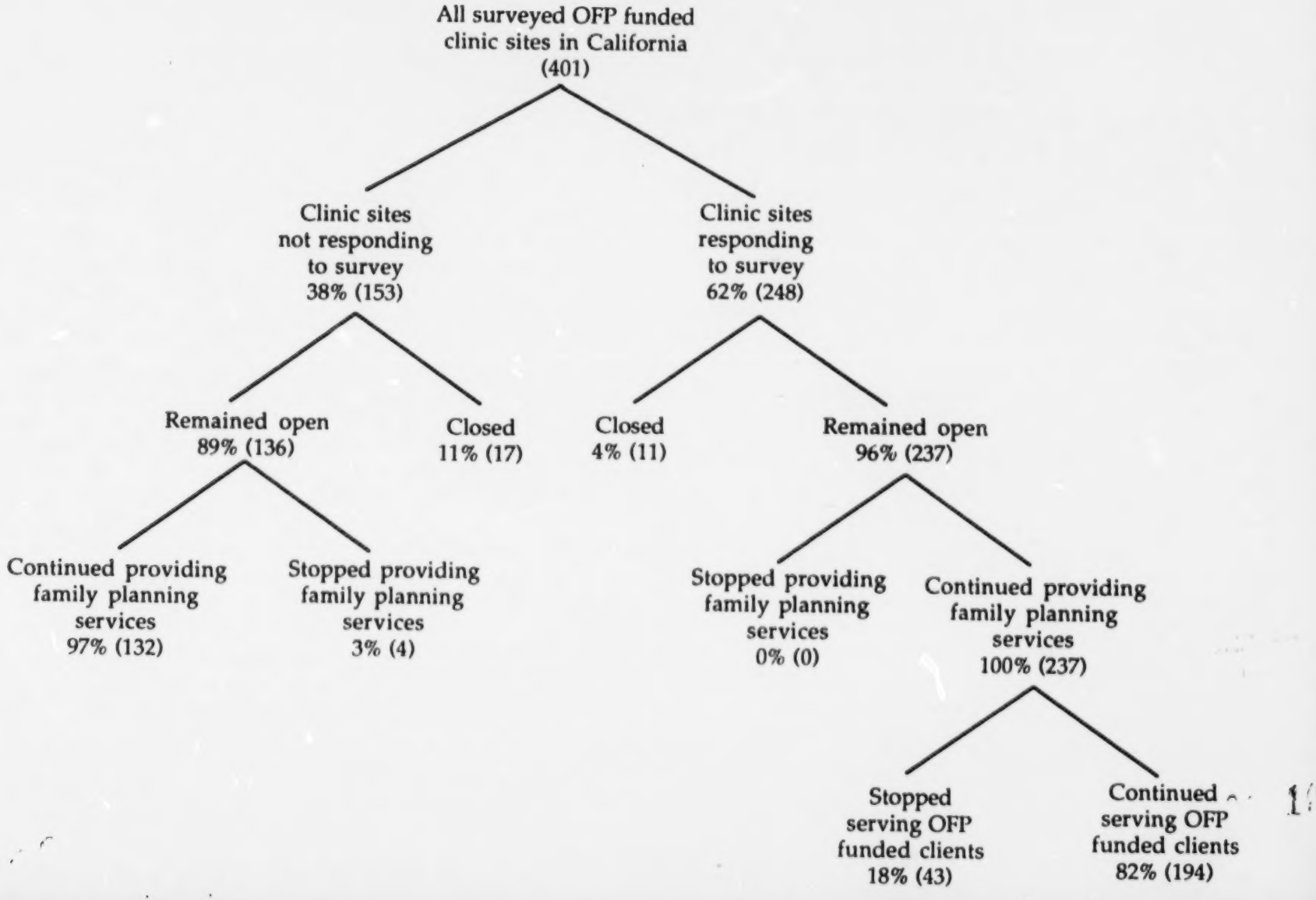
Clinics that Closed, Discontinued Providing Family Planning Services, or Stopped Serving OFP-Funded Clients

In the months following the budget cut, 28 clinics throughout the state closed, representing 7 percent of surveyed clinics. An additional four clinics remained open but discontinued family planning services altogether. In addition, 43 clinics continued to provide family planning services but stopped serving OFP-subsidized clients. Therefore, a total of 19 percent of surveyed OFP-funded clinic clinics in 20 counties became inaccessible to all clients who relied on subsidized family planning services. (Note: Clinics vary greatly in the number of hours per week that they provide services. Service hours range from eight hours per day, five days per week to as little as four hours on one day per week at one site.)

Table 1. Status of OFP-Funded Clinics Following Budgetary Cutbacks

Status of Clinic	Number	Percent
Remained open and continued providing family planning services to OFP-funded clients	326	81
Remained open but stopped serving OFP-funded clients	43	11
Remained open but discontinued providing any family planning services	4	1
Clinic site closed	28	7
Total	401	100

Figure 1. Disposition of California Office of Family Planning Clinics Following Budget Cuts (1989-1990)


All surveyed OFP funded clinic sites in California (401)
Clinic sites not responding to survey 38% (153)
Clinic sites responding to survey 62% (248)
Remained open 89% (136)
Closed 11% (17)
Closed 4% (11)
Remained open 96% (237)
Continued providing family planning services 97% (132)
Stopped providing family planning services 3% (4)
Stopped providing family planning services 0% (0)
Continued providing family planning services 100% (237)
Stopped serving OFP funded clients 18% (43)
Continued serving OFP funded clients 82% (194)

As shown in Table 2 and Map 1, 20 of California's 58 counties experienced varying levels of clinic closures and overall reductions in the availability of local services to OFP-eligible clients as a result of the funding cuts. Only counties that experienced a reduction in clinics caring for OFP-subsidized clients (i.e., had clinics that closed, or stopped providing family planning services, or no longer provided services to OFP clients) are included in this table. The remaining 38 counties did not experience reduced access to clinics, although clinics in these counties may have experienced the cutbacks in other ways, as described later in this report. The 20 counties experienced a range of between 4 percent and 100 percent reduction in clinics caring for OFP-subsidized clients. While counties vary widely in their geographic size, as well as in numbers of clients served, both rural and urban counties were affected. Rural areas may have experienced the greatest impact since few other resources exist in these areas.

Even prior to this funding cut and the resulting reduction in access to subsidized family planning services, 44 percent of the estimated 2.1 million women in California eligible* for financially assisted family planning services did not receive or avail themselves of these services (OFP, 1989). OFP provided services to 22 percent of eligible women, and 34 percent of these women were certified Medi-Cal eligible. Map 2 shows the proportion (by county) of unserved women who were eligible for financially assisted family planning services.

Nine of the counties that experienced reduced access to subsidized family planning services were also among the 20 counties with the highest teen birth rates in the state (DHS, 1991). Map 3 shows 1989 birth rates to teenage mothers (age 15-19) in counties with reduced access to OFP services.

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* *Eligible* is defined as having income at or below 200% of federal poverty guidelines.

Table 2. Location of Clinics with Reduced Access, by County

County	OFP clients served in 1988/89* (a)	Total number of OFP clinics before cuts 1988/89* (b)	Number of clinics that closed, discontinued family planning services or stopped serving OFP clients** (c)	Percent reduction in clinics caring for OFP-subsidized clients*** (d)
Alameda	14,877	23	1	4
Butte	4,614	8	2	25
Contra Costa	14,297	11	3	27
Fresno	9,773	10	1	10
Glenn	501	5	3	60
Los Angeles	127,702	108	18	17
Madera	1,483	2	2	100
Merced	4,848	6	1	17
Monterey	7,982	6	2	27
Orange	32,488	15	4	27
Placer	1,789	4	1	25
San Bernardino	20,243	12	11	83
San Diego	52,658	39	7	18
San Francisco	18,017	12	1	8
San Joaquin	9,712	7	6	14
San Luis Obispo	4,925	8	3	37
Santa Clara	16,780	19	3	16
Santa Cruz	8,734	4	3	74
Stanislaus	6,433	8	1	12
Tulare	4,979	5	2	40
Total	362,835	312	75	24

* Source: State Office of Family Planning, *Office of Family Planning Annual Report, Fiscal Year 1988-89* (1989).

** Source: Survey responses and phone calls to nonrespondents who either represented clinics that were closed or clinics that discontinued providing OFP-subsidized family planning services.

*** (d) = (c)÷(b)

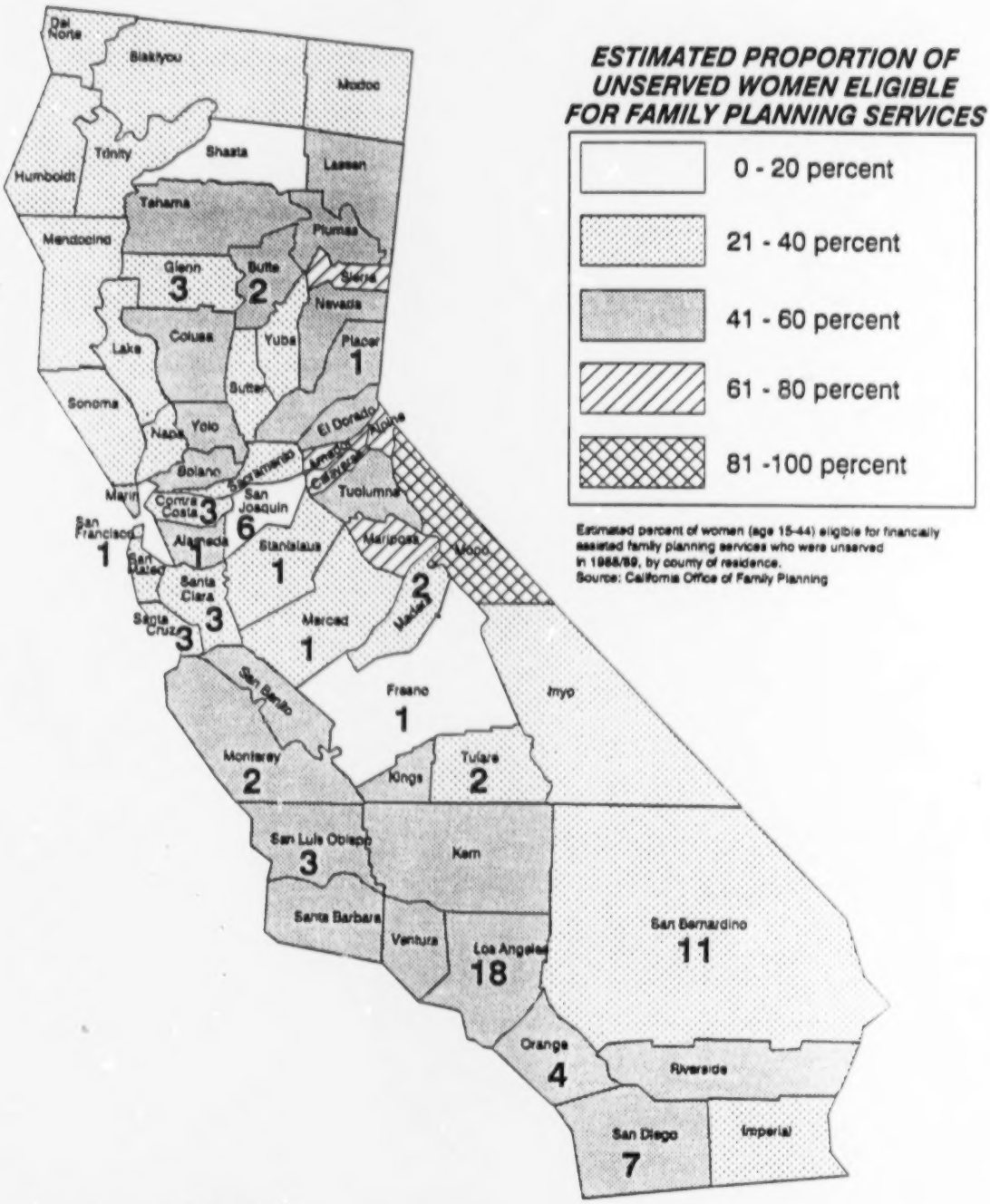
Map 1. California Counties with Reduced Accessibility to Family Planning Services*

Sites By County

Alameda	1	Placer	1
Butte	2	San Bernardino	11
Contra Costa	3	San Diego	7
Fresno	1	San Francisco	1
Glenn	3	San Joaquin	6
Los Angeles	18	San Luis Obispo	3
Madera	2	Santa Clara	3
Merced	1	Santa Cruz	3
Monterey	2	Stanislaus	1
Orange	4	Tulare	2

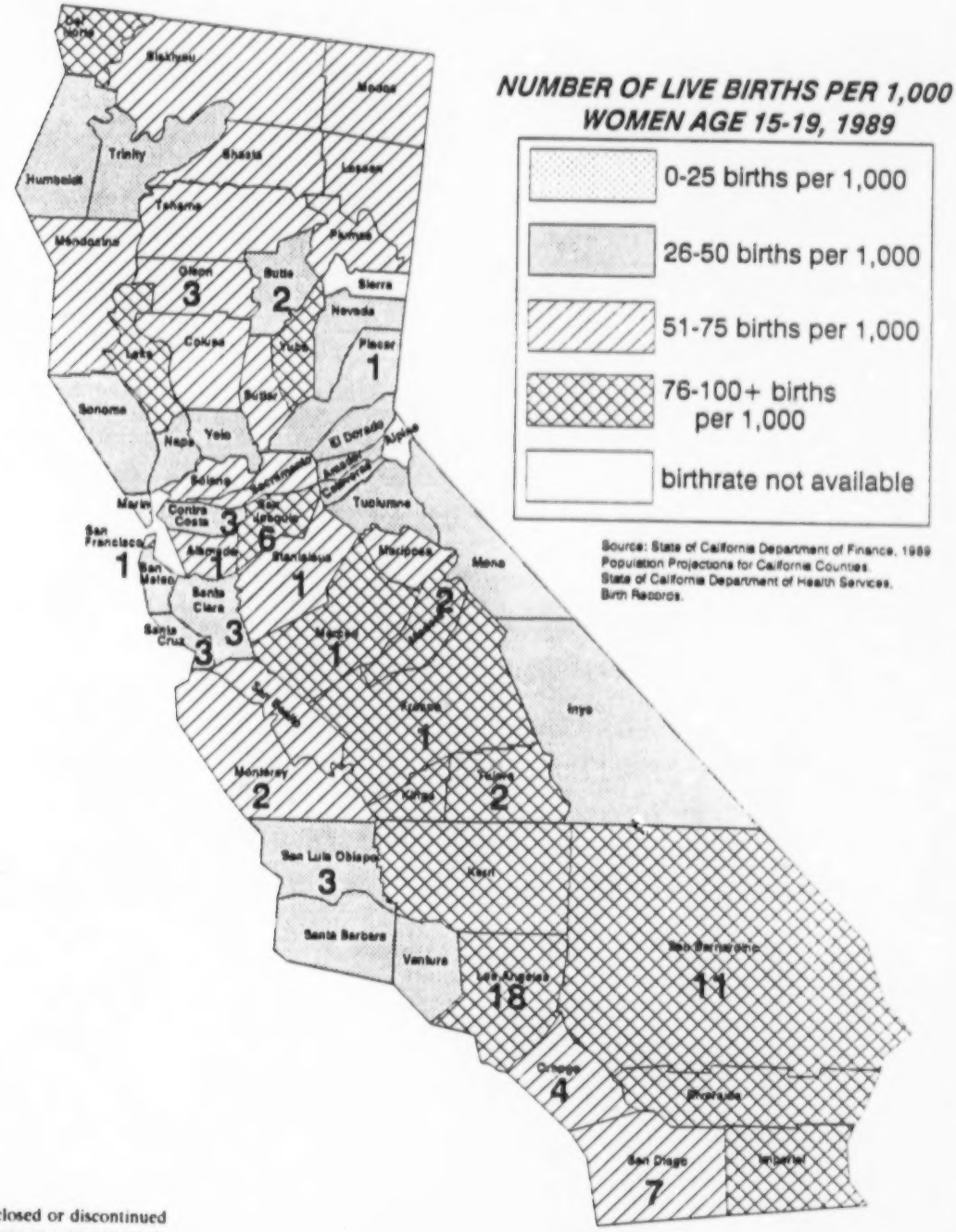
*75 sites that closed or discontinued providing services or were not serving OFP clients during the funding cutback.

Map 2. Reduced Accessibility to Family Planning Services* by Unserved Women Eligible for Care



*75 sites that closed or discontinued providing services or were not serving OFP clients during the funding cutback.

Map 3. California Counties with Reduced Accessibility to Family Planning Services* by Birth Rates to Teenage Mothers (Age 15–19), 1989



*75 sites that closed or discontinued providing services or were not serving OFP clients during the funding cutback.

Characteristics of Closed or Discontinuing Clinics

A detailed descriptive analysis of clinics that closed or discontinued family planning services is available only for clinics that responded to the survey. Limited information (e.g. whether family planning services were still available and the clinic's sponsorship, setting and size) was gathered from nonresponding clinics by telephone.

Of the 32 clinics that closed or discontinued family planning services, 60 percent (19 clinics) were publicly owned (city, county, or university affiliated). The remaining 40 percent were private, not-for-profit agencies. Thirty-one percent (10) of the clinics were rural and 69 percent (22 clinics) were suburban/metropolitan or inner city.

Clinics were asked for their total number of client visits for 1988-1989, and were then grouped by these figures into categories of small (0-1,000 patient visits per year), medium (1,001-3,000 patient visits per year), and large clinics (3,001+ patient visits per year) (see Table 3). Size information on 28 of the 32 clinics that closed or discontinued family planning services was available for analysis; four clinics did not report the number of clients they served. Eighteen clinics (64 percent) of those forced to close their doors or eliminate family planning services could be categorized as small. This proportion far exceeds the proportion of small-category clinics (43 percent of all clinics across the state) that remained open.

Table 3. Description of Family Planning Clinics that Closed or Discontinued Family Planning Services

SPONSORSHIP:

60% (19) publicly owned clinics (city, county or university affiliated)
40% (13) private, nonprofit community agencies

GEOGRAPHIC SITE:

31% (10) rural communities
69% (22) suburban/metropolitan

CLIENT BASE – SIZE OF CLINIC:*

64% (18) small agencies (0 - 1,000 client visits per year)
22% (6) medium agencies (1,001 - 3,000 client visits per year)
14% (4) large agencies (3,001+ client visits per year)

*Missing data on 4 agencies

Referral Patterns of Clinics that Closed or Stopped Serving OFP Clients

Closed clinics. Eleven of the 28 clinics that closed as a result of the budget reduction returned a completed survey questionnaire. Ten clinic administrators indicated that they referred clients to other sources of family planning services after their clinic no longer provided direct services. The clinics to which clients were referred typically accepted Medi-Cal clients, and most were also OFP-funded county facilities (see Table 4). Distances to the new clinics were 11 to 24 miles away from the referring clinic for a little over half of the closed sites. Public transportation to the new clinics was not available for nearly half of the referrals. Thus, both distance and lack of adequate transportation, as well as lack of familiarity with the new clinic, most likely acted as additional barriers to clients who were referred elsewhere for services.

Clinics no longer providing OFP-subsidized family planning services. All of the responding clinics that remained open continued to provide family planning services. However, 43 indicated that they no longer provided care to OFP-subsidized clients. Although the survey did not specifically ask how former OFP-subsidized clients would pay for their visits, some clinics continued to serve these clients despite the lack of state reimbursement, while others referred clients to another provider, and some did both. As previously discussed, a number of clinics sought additional funding in order to provide free or low-cost services for clients who were formerly eligible for OFP reimbursement. Anecdotal comments by clinic managers indicated that some of the former OFP-subsidized clients were served, but that their fees were offset by an increase in fees charged to paying clients. Only 17 (40 percent) of the 43 clinics that stopped serving OFP-subsidized clients indicated that they referred their clients to other sources of family planning care. Again, the clinics these clients were referred to were likely to be county facilities that accept Medi-Cal (see Table 4).

The clinics that no longer accepted OFP-subsidized clients were less likely than the closed clinics to refer clients to another OFP-funded agency. This finding may reflect the fact that clinics responding to the survey were located in areas where no other OFP-funded providers were available, and thus referrals to other OFP-funded facilities were not feasible. Unfortunately, the survey questionnaire did not solicit information that could explain potential reasons for differences in referral patterns. While the majority of clinics referred clients to an agency that was within 10 miles, nearly half (47 percent) of the referring clinics indicated that public transportation was not available to these alternative facilities.

Table 4. Characteristics and Distance to Referral Clinics

Characteristics of Referral Clinics	Total (27 clinics)		Clinics That Closed (10 clinics)		Clinics That Stopped Serving OFP Clients (17 clinics)	
Clinics accepting Medi-Cal	96%	(26)	100%	(10)	94%	(16)
Another OFP clinic	48%	(13)	90%	(9)	24%	(4)
County facility	85%	(23)	80%	(8)	88%	(15)
Distance From Clinic to Referral Site						
10 miles or less	59%	(16)	30%	(3)	76%	(13)
11 to 24 miles	26%	(7)	60%	(6)	6%	(1)
25 to 49 miles	8%	(2)	0%	(0)	12%	(2)
50 to 99 miles	8%	(2)	10%	(1)	6%	(1)
Total	100%	27	100%	10	100%	17

Clinics Remaining Open and Providing Family Planning Services

Service Changes

Some clinics experienced, or expected to experience, numerous and varied changes in the level of services they would be able to provide if funding were not restored before the end of the fiscal year. Thirty-two percent (74) of the 229 clinics that provided information on the number of hours they were open in FY 1988-1989 had already reduced the number of clinic hours available to family planning clients. Sixty-six percent (151 clinics) experienced no change in hours and 2 percent (4) increased their total number of clinic hours. Table 5 shows the number and proportion of clinics by the number of hours that services were reduced.

Table 5. Clinics That Reduced Hours of Service, by Percentage of Hours Reduced

Percent Reduction in Hours Open	Clinics % (N)
1 - 10	16 (12)
11 - 20	15 (11)
21 - 30	34 (25)
31 - 40	19 (14)
>40	16 (12)
Total	100 (74)

Fifty-one percent (112) of the 218 clinics that provided information on changes in staffing reported that they had already decreased their staff. However, 48 percent (105) had experienced no changes in staffing at the time of the survey. Only one clinic (0.5 percent) had increased its staff. The proportions by which the 112 clinics decreased staff are presented in Table 6. Of the 112 clinics, 109 specified which staff positions had been reduced or eliminated: 60 percent (65 clinics) reported that their physician and nurse practitioner/public health nurse hours had been reduced, many in combination with their clerical, nurse, and health educator service hours. These staff reductions were particularly problematic because it has become increasingly difficult, as noted below, for family planning programs to retain nurse practitioners in their staff positions. As a result of the funding crisis many nurse practitioners found employment with other clinics, or in private practice or health maintenance organizations.

In the aftermath of the budget reductions many clinics have experienced difficulty re-recruiting nurse practitioners. Even after the reinstatement of funding, recruitment has been difficult because the salaries traditionally offered to nurse practitioners, which are influenced by low OFP reimbursement rates, are often far lower than those available in other health facilities. In order to succeed in their recruitment efforts, many clinics have had to raise salaries, often resulting in a decrease in the hours worked by other support staff in order to maintain adequate clinical coverage. Other recruitment strategies have included more flexible hours, more opportunities for continuing education, and offering practitioner training opportunities to nurses with an understanding that they would return to their work sites for a designated period of time to offset the investment in training costs.

As shown in Table 6, the proportion of staff that was reduced varied by clinic. While 21 percent (23 clinics) reported a 10 percent (or less) staff reduction, nearly one-fourth (27 clinics) experienced staff reductions of from 41 percent to 50 percent, while nearly one-fifth (20 clinics) experienced a 21 percent to 30 percent reduction.

Table 6. Percent Reduction in Family Planning Staff by Proportion and Number of Clinics

Percent Reduction In Staff	Clinics % (N)
1 - 10	21 (23)
11 - 20	15 (17)
21 - 30	18 (20)
31 - 40	15 (17)
41 - 50	24 (27)
51 - 60	0 (0)
61 - 70	0 (0)
>70	7 (8)
Total	100 (112)

Along with reductions in clinic staff, the other reported service changes that had been planned or instituted were the development of new patient sliding-fee schedules for non-OFP-funded clients (reported by 25 percent of clinics remaining open) and the termination of some services (reported by 26 percent of clinics remaining open). Some survey repondents planned to discontinue or reduce dysplasia services, as well as postpone annual physical exams.

Clinics experienced a markedly reduced ability to serve clients seeking family planning services during the period of the budget cuts. For the one-year period between July 1, 1988 and June 30, 1989, nine of 233 responding clinics (4 percent) had to turn clients away due to lack of sufficient funding. At these clinics, the OFP contract amounts had been fully billed long before the completion of the fiscal year. For the three-month period of August 15 to November 15, 1989, this figure jumped to 79 of 199 responding clinics (40 percent) indicating that they had to turn clients away due to insufficient funding. In addition, 66 of 125 responding clinics (53 percent) expected to turn away a greater number of clients during the remainder of FY 1989-1990 if funds were not restored within a few months.

Funding Patterns

Among the clinics that continued to provide family planning services, 181 of 199 respondents (91 percent) indicated that they intended to continue serving OFP-funded clients for as long as financially feasible even after their OFP monies were exhausted. Clinics reported a variety of means by which their budgets would be augmented in order to continue contraceptive services. Clinics were

asked to check as many sources on the survey questionnaire as were relevant to their site. A majority of clinics reported collecting fees from clients when OFP funds were exhausted. Clinics were allowed to ask clients for payments greater than the copayment fee schedule established by OFP only after their state funds were exhausted. Twenty-six percent (54 clinics) of 209 responding clinics reported collecting copayments from a greater proportion of clients as compared with the previous fiscal year. Many clinics cited more than one source of alternative funds (e.g., Title X and county funds) used to supplement their budgets so that they could continue to serve the poorest of their clients. Use of Title X funds can refer to a clinic's original allocation or can include additional funds made available by a combination of administrative cost savings through staff reductions and termination of the National Priority Project for Chlamydia. These funds were shifted in an attempt to offset the cuts to agencies that were hardest hit and/or that had fewer (or no) other resources to draw upon at the time of the cutbacks. Of the 52 clinics that described "other" sources, 62 percent (32 clinics) reported that Medi-Cal would be used, and 40 percent (96 clinics) indicated that they would use donations. Other sources mentioned were insurance, over-performance earnings from the previous year, and fundraising. The percentages presented in Table 7 below pertain to the 209 clinics that used at least one alternative source of funding.

Table 7. Clinics Planning to Utilize Alternative Funding Sources

Alternative Source of Funding	Clinics	
	%	(N)
Title X	49	(103)
County funds	46	(96)
Foundation funds	10	(20)
Client fees	84	(176)
Other	52	(108)

Many clinics used a combination of funding sources to enable them to continue providing contraceptive services to OFP-eligible clients. Table 8 presents the number of different funding sources tapped by clinics that reported using at least one source of alternative funding. Twenty percent of those providing information on sources of alternative funding reported only one source, with the majority relying on client fees. A common combination of two sources were county funds and client fees. An example of three funding sources would be the use of Title X, county funds, and client fees. There did not appear to be a clear relationship between setting (rural vs. nonrural) and the number of funding sources used. Rural clinics were more likely to use one or three sources while nonrural clinics were more likely to use two or four sources. Five clinics

did not specify whether they were rural or nonrural. A complete listing of the combination of funding sources used in included in the Appendix.

Table 8. Number of Alternative Funding Sources, by Clinic Setting

Number of Funding Sources Used	All Clinics %	(N)	Rural Clinics %	(N)	Nonrural Clinics %	(N)
One	20	(42)	24	(15)	18	(25)
Two	31	(65)	27	(17)	32	(45)
Three	38	(79)	43	(27)	36	(51)
Four	11	(23)	6	(4)	14	(20)
Total	100	(209)	100	(63)	100	(141)

Clinics reporting that they intended to continue serving OFP clients were asked if these alternative funding sources would be sufficient to meet their funding needs to maintain prior service levels through June 30, 1990. Seventy-six percent (106 clinics) of the 178 responding clinics stated that these revenues would not be sufficient. The survey also asked respondents to comment on how they planned to fund family planning services should revenues prove to be inadequate. As shown in Table 9, most of the 106 clinic administrators who responded mentioned using more than one strategy to allow them to continue providing services. (Note: this was an open-ended question and administrators could report as many strategies as they were planning to use.) The highest proportion of clinics (29 percent, 31 sites) indicated that they would rely on client fees and donations to maintain services. One-fourth of the clinics (26 percent) indicated that they would have to serve fewer clients, make fewer services available, and decrease clinic staff. Community fundraising and seeking county and city subsidies as well as private agency funds were also options chosen by clinics as means to maintain services. As one respondent commented:

> We are so committed to not cutting services that we are willing to run in the red and cut our education department and increase private fundraising in order to accommodate to the cuts. But obviously, we can't do this more than one year.

Table 9. Strategies Planned to Maintain Family Planning Services

Strategy	Clinics (N=106)	
Client fees and donations	29%	(31)
Fewer patients, services, & staff	26%	(28)
Community fundraising	23%	(24)
Agency private funds	12%	(13)
Discontinue program(s)	8%	(8)
Medi-Cal	8%	(8)
County or city subsidies	7%	(7)
"Holding out" for legislative changes	5%	(5)

The clinics were also asked for the dollar amount of their total budgets for family planning services for FY 1988-89 and FY 1989-90.* Seventy-four percent (134) of responding clinics showed decreases in their 1989-90 family planning budgets, and 19 percent (35 clinics) reported increases. An additional seven percent (13 clinics) experienced no budget changes. Table 10 summarizes the percentages of budgetary increases or decreases for clinics' overall family planning budgets in FY 1989-1990. (Note that this table does not include the clinics that closed.) The percent of the budget decreases of nearly a third (30 percent) of the 134 clinics reporting ranged from 51 percent to over 70 percent of their 1988-89 budgets. One-fourth (24 percent) of the clinics reported budgetary decreases of between 30 percent and 50 percent of their previous year's budget. Of the 35 clinics that reported *increases*, the majority (77 percent) experienced only a 10 percent increase in their overall budgets, while another 15 percent reported increases of between 11 percent and 30 percent. Only three clinics (8 percent) reported a substantial increase in their budget of over 70 percent, perhaps reflecting a consolidation of services within one community. Increases in overall funding may also reflect special one-time-only private foundation support and direct public fundraising efforts.

* The survey was administered in November 1989. By the end of the fiscal year, clinics would most likely have experienced increases due to the restoration of OFP funds and additional fundraising efforts.

Table 10. Percentages of Family Planning Budget Increases or Decreases, FY 1988-89 to FY 1989-90

Percent Change in Budget	Clinics With Budget Decreases %	(N)	Clinics With Budget Increases %	(N)
1 - 10	16	(22)	77	(27)
11 - 20	10	(14)	9	(3)
21 - 30	20	(28)	6	(2)
31 - 40	10	(14)	0	(0)
41 - 50	14	(19)	0	(0)
51 - 60	16	(22)	0	(0)
61 - 70	10	(14)	0	(0)
>70	4	(1)	8	(3)
Total	100	(134)	100	(35)

Client Use of Services Before and After Budget Cuts

Clinics were asked for the total number of OFP-funded client visits for FY 1988-89 and their estimate for FY 1989-90. Two hundred and twenty-eight clinics averaged 2,303 visits for FY 1988-89, and 215 clinics predicted an average of 1,062 visits for FY 1989-90. This predicted average number of visits for FY 1989-90 was less than half the previous year's actual visits. At the time this survey was conducted clinics did not know when or if funding would be restored. According to the OFP annual reports for 1988-89 and 1989-90, actual billed visits decreased from 900,431 to 650,548, a decrease of some 28 percent (OFP, 1988-89 and OFP, 1989-90). These numbers are based on visits billed to OFP. Clinics that did not bill for clients served after they had utilized all their OFP funds are not represented here. This large decrease dramatically illustrates the significant impact the budgetary cuts had on clients served by the OFP system, contrasting sharply with the 3 percent decrease experienced from FY 1987-88 to FY 1988-89 and the 1 percent increase recorded from FY 1986-87 to FY 1987-88.

Clinics were also asked to estimate the percentage of their OFP-subsidized clients who use their family planning site as their primary source of health care. The 155 responding clinics provided a range of answers of from 9 percent to 98 percent or an average of 73 percent who relied on family planning clinics for ongoing comprehensive care. As noted by a patient services director of a rural county agency:

> Although the program is known for its excellent delivery of family planning services, overlooked is that it is also the primary care provider for many low-income women. Low-income women who

have gone through our care are found to have, many times, a life-threatening health problem that would have gone on undetected because of unaffordable primary care services.

Availability of Screening Procedures and Special Services

Pap smears. In addition to providing methods of birth control, clinics perform a number of screening procedures. Two hundred and seventeen clinics (88 percent of all responding clinics) provided an average of 1,236 pap smears in 1988-89 (range = 10 to 5,700 exams). An average of 11 percent of these pap smears were abnormal, requiring further services. Eight of the 11 clinics that closed also provided information on the numbers of pap smears they had previously performed. A total of 1,755 pap smears were performed among these eight clinics, with 11 percent of clients being diagnosed as having abnormal results (200 abnormal exams). Although we are unable to track whether women who use family planning clinics as their source of primary health care sought services elsewhere, it is likely that a certain proportion of these clients might not pursue annual physical exams without an available clinic in their vicinity.

Dysplasia services. Because the Office of Family Planning did not reimburse for dysplasia services (diagnosis and treatment after receipt of abnormal pap smear results) during the period of funding reduction, many clinics faced the dilemma of attempting to obtain reimbursement for this service directly from the client, or from a third party, or alternatively, eliminating these services entirely. A number of clinics opted to eliminate the dysplasia services necessary for the follow-up treatment of abnormal pap smears. One hundred and thirty-two clinics reported providing dysplasia services in FY 1988-1989. The following year, however, only 116 clinics reported providing these services, representing a 12 percent decrease. The clinics that did continue to offer dysplasia services were then asked how they were funded. The great majority (76 percent) of the 96 responding clinics charged clients fees for these services (see Table 11).

These services can be very expensive, depending on the nature of the problem. At one county hospital a colposcopy (examining the cervix through a microscope) would cost $83 in professional fees. If an endocervical biopsy (taking tissue from the cervix) is necessary, that would add an additional $73 in professional fees. Cryosurgey to remove warts (HPV) would cost $140 for each visit. If the woman does indeed have cancer, laser surgery runs from $350 to $750. (Note: These fees do not include facility or pathology fees. OFP does not necessarily reimburse at these rates.) Faced with the request for payment in addition to the discomfort of some of these procedures, women do not always return for the necessary therapy.

Table 11. Form of Payment Requested by Family Planning Clinics for Dysplasia Services During OFP Funding Cuts

Form of Payment	Clinics %	(N)
Client Fees	76	(73)
County	17	(16)
Combination	4	(4)
Other	3	(3)
Total	100	(96)

Pregnancy testing only. Payment for pregnancy-testing-only clients - those who come to the clinic solely to determine if they are pregnant and who are not enrolled as contraceptive clients - was not reimbursed during the budgetary cutbacks. It is important to note that pregnancy testing is often the way in which women enter the family planning clinic system, as clinic staff counsel women regarding their potential risk for pregnancy. OFP did continue to reimburse for contraceptive clients who needed a pregnancy test, but who also received additional contraceptive services as part of this visit. One hundred and sixty-four clinics continued to provide pregnancy-testing-only services. The majority of clinics (69 percent) paid for these tests through county funds (see Table 12).

Table 12. Form of Payment for Pregnancy-Testing-Only Services

Form of Payment	Clinics %	(N)
County	69	(113)
Client Fees and Medi-Cal	18	(29)
County and Client Fees	7	(11)
Client Fees Only	3	(5)
Other	3	(6)
Total	100	(164)

STD screening. One hundred and seventy-nine clinics provided an average of 1,524 laboratory screening tests (range = 5 - 23,095 lab tests) for sexually transmitted diseases (STDs) in 1988-89. An average of 14 percent of these laboratory results were positive. Eight of the 11 clinics that closed which had completed the survey reported providing a total of 1,181 STD tests. Among this subsample of clinics, only five of the eight could report the number of positive

results. The positivity rate for these clinics was 10 percent. Again, while we are unable to trace whether clients attended other clinics for these services during the period of the funding cuts, a number of additional barriers (distance, transportation, unfamiliarity with site, request for payment, etc.) could hamper the efforts of clients to seek care.

Sterilization and infertility services. Family planning clinics can also be sources of male and female sterilization and infertility services. Agencies that reported continuation of family planning services were asked if they continued to provide sterilization or infertility services. Sixty clinics responded that they no longer provided one or more of these specialized services. However, the wording of this question made it unclear as to when, if ever, the clinic provided the service. Therefore, we relied on OFP billing data for infertility and sterilization services. Fifteen of the 60 clinics (25 percent) reporting they were no longer providing one of these services had been providing them at the beginning of FY 1988-89. From FY 1988-89 to FY 1989-90 there was a 21 percent drop in the number of clinics providing these services. Some clinics appear to have eliminated them and reallocated the money for contraceptive services. Without OFP approval an OFP contractor may not reallocate sterilization and infertility funds to provide contraceptive services. Following the funding restoration, the allocation for these services was raised to 80 percent of the amount originally budgeted for these services for 1989-90.

Use of Medi-Cal for Family Planning Services

Survey results document that 38 percent (86 clinics) of the 232 responding clinics reported an increase in the number of Medi-Cal-enrolled clients as compared with the previous fiscal year; 1 percent reported a decrease, and 40 percent (93 clinics) reported no change. Of those clinics that showed an increase, 41 percent experienced an increase of between 1 percent and 10 percent in the number of Medi-Cal beneficiaries, while 31 percent experienced an 11 percent to 20 percent increase. One-quarter (24 percent) of these clinics reported a 21 percent to 30 percent increase, and 3 percent increased their Medi-Cal client load by 31 percent to 50 percent.

A relatively new improvement in the Medi-Cal application process is the placement of eligibility workers at clinics. This model effort has been shown to be successful in Alameda County by decreasing the time it takes to enroll clients in the program. However, placement of eligibility workers in clinics is not yet available in all counties, and Medi-Cal requires a minimum expected caseload of eligible clients before placement can be authorized, a requirement not all clinics can meet. It is also important for eligibility workers to be available after school hours in order to qualify adolescent clients. Thirty-nine clinics (26 percent of those responding) reported that they had an on-site Medi-Cal eligibility worker, and 16 of these clinics had instituted this services since September 1990. Ten other clinics reported they were working with their county social services

department to initiate such a program. Counties that had placed Medi-Cal eligibility workers at selected clinics at the time of the survey included: Alameda, Fresno, Humboldt, Kern, Los Angeles, San Diego, San Francisco, San Luis Obispo, San Mateo, San Joaquin, Santa Barbara, Santa Clara, Tulare, and Yolo. (Not all clinics in each of these counties had an eligibility worker available on site.)

Timely Access to Care

Results of the survey show that clients received less timely service following the budget cut. Eighty-seven percent (201 clinics) of clinics responding to this question indicated they were able to provide requested appointments within two weeks or less in FY 1988-89; after budget reductions, only 63 percent (145) of the clinics were able to provide appointments within two weeks of a request. The waiting time increased in more nonrural (28 percent) then rural clinics (19 percent). Table 13 shows the amount of time clients waited for appointments in FY 1988-89 compared to the reported waiting time the following year.

Table 13. Length of Waiting Time for Appointments, by Clinic Setting and Year

Waiting Time for an Appointment	All Clinics		Rural Clinics		Nonrural Clinics	
	1988-89 (N=231)	1989-90 (N=230)	1988-89 (N=66)	1989-90 (N=66)	1988-89 (N=160)	1989-90 (N=159)
< 2 weeks	65%	47%	55%	45%	70%	48%
2 weeks	22%	16%	29%	20%	20%	14.5%
3 weeks	9%	21%	15%	27%	6%	19%
4 weeks	3%	11%	1%	5%	3%	14.5%
5 weeks	1%	4%	0%	3%	1%	3%
6 weeks	0%	1%	0%	0%	0%	1%
Total	100%	100%	100%	100%	100%	100%

Clinic administrators were asked how long they thought clients were willing to wait for an appointment. Of the 161 responding clinics, 42 percent (68 clinics) said clients were willing to wait less than two weeks, 38 percent (61) stated two weeks, 16 percent (26) said three weeks, and 4 percent (6) said four weeks. Many respondents commented that the longer clients had to wait for an appointment, the more likely they were not to show up for their appointment.

Clinics did in fact report changes in their rates of broken appointments. Of the 232 responding clinics, 35 percent (81) observed increases in the rate of "no-

shows," with the majority of clinics experiencing an 11 percent to 20 percent increase in missed appointments. Some clinics reported a decrease in their rates of broken appointments, with 10 percent (23 clinics) indicating that their missed appointment rates had decreased by up to 30 percent. Thirty-nine percent (91 clinics) experienced no change in their rate of broken appointments. Sixteen percent (37 clinics) did not know if there was a change and 16 clinics did not respond to this question. Nonrural clinics were more likely than rural ones to experience more broken appointments. Many respondents gave reasons as to why these changes were occurring, most commonly that clients lacked money to pay for the increased fees (70 percent or 87 clinics), and that clients "gave up waiting" when they had to wait longer for an appointment (26 percent).

Table 14. Changes in Broken Appointments, by Clinic Setting

Changes in Broken Appointments	All Clinics		Rural Clinics		Nonrural Clinics	
Increase	35%	(81)	30%	(20)	38%	(60)
Decrease	10%	(23)	7%	(5)	11%	(18)
No change	39%	(91)	46%	(31)	35%	(56)
Unknown	16%	(37)	17%	(11)	16%	(26)
Total	100%	(232)	100%	(67)	100%	(160)

Table 15 shows the amount of change in broken appointments experienced by clinics. Two clinics with decreases in broken appointments did not provide figures on how much of a change they experienced. The majority (56 percent) of clinics that had increases in broken appointments saw an 11 percent to 20 percent change. The majority of clinics with decreases experienced a change in the range of 1 percent to 10 percent.

Table 15. Percent Change in Number of Broken Appointments

Percent Change In Broken Appoint's	Clinics With Increases in Broken Appoint's %	(N)	Clinics With Decreases in Broken Appoint's %	(N)
1 - 10	14	(11)	62	(13)
11 - 20	56	(45)	19	(4)
21 - 30	11	(9)	14	(3)
31 - 40	6	(5)	0	(0)
41 - 50	11	(9)	5	(1)
51 - 60	2	(2)	0	(0)
Total	100	(81)	100	(21)

DISCUSSION

Although the funding restrictions on the Office of Family Planning were in effect for only seven months, the budgetary cuts had a dramatic impact on the state's network of family planning clinics. Twenty-eight clinics closed, four clinics discontinued family planning services, and an additional 43 clinics stopped serving OFP-subsidized clients. Thus, a total of 75 clinics were no longer accessible to family planning clients needing subsidized care.

Perhaps as damaging were a number of other program impacts, including fewer available appointment slots, reduced staffing, increased waiting times, and increased client fees for supplies and services. Some services that were no longer reimbursed by OFP were also eliminated during the cuts: STD testing, dysplasia treatment, and pregnancy testing only. There was also a decrease in the number of clinics providing male and female sterilization and infertility services.

The potential long-term effects are well described by one survey respondent:

> Reduction in funds will have a significant impact on several clinic programs. AIDS education and testing opportunities will be reduced. Women will delay prenatal care which is encouraged at pregnancy testing visits. Family planning education opportunities and STD prevention opportunities will be decreased. Lack of treatment for male partners is a waste of money.

The OFP-funded Information and Education (I&E) Projects were also affected. In fiscal year 1988-1989, 55 I&E projects served 107,000 people (OFP, 1988/89). Only 42 projects survived the cuts to receive the restored monies. In FY 1989-90 these I&E projects served 94,000 people, a 12 percent reduction from

the previous year (OFP, 1989/90). Because they often have very small staffs (sometimes only one or two individuals) and little alternative funding, the I&E projects had a particularly difficult time resuming their programs again when funding was restored. A major problem has been the lack of available staff and the necessary recruitment time to replace the original group of health educators dismissed as a result of the funding cut.

The survey also documents that California's family planning clinics utilized every possible resource available to remain open and maintain a high level of services pending the hoped-for restoration of funds. Some of these somewhat temporary sources of funding, such as "bridging grants" from foundations and assistance from their counties, allowed these clinics to stay open. As one director said,

> We hope to hang on and keep our services intact in anticipation of restored funding. It is much more expensive to lose valuable staff, to have to replace and retrain them.

Because this survey was completed during the funding reduction we cannot provide a great deal of detail on the restart efforts. Many clients chose not to obtain services from these clinics when they were asked to provide a copayment or when they heard that clinics were closing. It takes a great deal of effort to inform eligible women that curtailed services are available again. In recognition of these problems, up to 10 percent of the restored funds were set aside for restart costs, including recruitment costs for staff and advertising of services for clients. Nonetheless, startup time has been considerable.

The temporary reduction in funding for many clinics had long-term consequences. Most dramatic has been the inability to recruit the nurse practitioners who form the backbone of clinic services. Many of these professionals sought employment elsewhere because of the instability of program funding as well as the relatively low salaries at OFP-funded clinics. In addition, family planning clinics continue to experience difficulty with the low level of reimbursement rates that are provided under their current contracts. Among other increases in funding to OFP by Governor Wilson is a clinical services augmentation of $10 million in fiscal year 1991-92 that will target services for sexually active adolescents and chemically dependent women. This increase is anticipated to allow OFP to reach more of the eligible but unserved women in this state. However, at this time no new reimbursement rate increases have been approved. While these new initiatives are much needed, clinic administrators report that insufficient funding to reimburse for clinic services hampers the administration of the current programs. An OFP rate study shows that OFP-funded providers are currently reimbursed at only 48 percent the rate of comparable Medi-Cal reimbursements (OFP Ad Hoc Advisory Committee, January 1991). Thus, additional funding would be required in order to support current service demands, as well as to augment the OFP's efforts to reach a greater portion of California's large and growing underserved population.

As shown in this study, continued state funding of the network of family planning clinics throughout California is imperative if women at risk of unintended pregnancy are to be served. Even brief periods of reduced funding levels can have a negative impact on the ability of family planning clinics to provide services. Stable funding and a commitment to the program by state leaders and policymakers are crucial to maintaining a system of family planning care that responds to California's growing needs.

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APPENDIX

Sources of Funding

Funding Sources	Number of Clinics	Percent of Clinics
County funds only	3	1.4
Client fees only	28	13.4
Other only	11	5.3
Title X + county funds	16	7.7
Title X + client fees	8	3.8
Title X + other	1	.5
County funds + client fees	21	10.0
County funds + other	1	.5
Client fees + other	17	8.1
Foundation grant + client fees + other	11	5.3
Title X + foundation grant + client fees	8	3.8
Title X + client fees + other	28	13.4
Title X + county funds + other	1	.5
Title X + county + client fees	17	8.1
County funds + client fees + other	14	6.7
Title X + foundation + client fees + other	1	.5
Title X + county funds + client fees + other	23	11.0
Total	209	100.0

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